Strategic Plan
for
Sustainable Improvements in the Health of Women and Children

Strategic Objective No. 5
(SO 5)

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CONTENTS

Strategic Plan for Sustainable Improvements in the Health of Women and Children (SO 5)

I. Introduction

The Mission will retain a focus on maternal and child health as its objective for health sector investments. Activities in support of this SO include improving the quality and availability of child and reproductive health services as well as ensuring the sustainability of improved systems through cost recovery and policy reform. The Mission program integrates family planning, child survival and safe motherhood activities, as well as female education initiatives, for greater impact. This approach is consistent with Agency guidelines and "best practices" worldwide. The mutually reinforcing objectives of fertility reduction and health improvements for women and children are directed to the Mission's subgoal of "Reducing Population Growth and Improving Health" as well as to the Agency's Goal 3, "World's population stabilized and human health protected in a sustainable fashion".

Without a healthy population, a nation cannot achieve broad-based sustainable development. We are working to reduce the impediments to sustainable development by improving health and population conditions. Improving maternal and child health contributes directly to promoting nationwide health as women and children are the most in need of services. Preventive interventions such as immunizations reduce adult morbidity and mortality as well. These achievements ensure that fertility and population growth rates do not outstrip the country's ability to provide adequate food and social services, that health and nutrition status are not impediments to children's ability to learn and adults' ability to produce and participate in their society, and that growth rates do not threaten the already precarious environment further. Health improvements are critical to improving the human condition, an important dimension of the Mission's Goal of "Broad-based sustainable development with improved quality of life".

Egypt has made impressive strides in increasing life expectancy and reducing unwanted fertility in recent decades. The most important health status gains have been in terms of prevalent childhood diseases, such as the immunizable diseases and diarrheas. These reflect successful vertical programs, which have received considerable international support. The infant mortality rate (IMR), which is one of the best indicators of overall well being of a society, has been reduced 42% in the last 13 years. The pace of change may have slowed in recent years, although with the still expanding population base, the numbers of children protected is growing. It is clear that our strategy to shift program focus to integrated approaches to ensure availability of quality reproductive care for women and child health care is correct.

Despite these gains, Egypt's aggregate health status is low relative to other countries at similar levels of income and education. For example, life expectancy at birth in Egypt was 62 years in 1993, while it was higher in Morocco, Jordan, Syria, China and most Latin American countries of similar or lower per capita income. Similarly, the infant and child mortality and maternal mortality are considerably higher than most countries of similar economic and educational status. While parts of Egypt's population still bear a large burden of the "diseases of underdevelopment", others are well advanced in the epidemiological transition and its associated increases in demands and expectations for more costly institution-based treatment.

II. Strategic Plan

A. Rationale

Although infant and child mortality have declined rapidly in the past years, deaths among young children remain unacceptably high (IMR of 62.7 and total under five mortality rate of 80.8 per 1,000 live births, 1993) for a country with good access to care and a moderate amount of spending on health. While the post-neonatal mortality rate has shown steady reduction until the 1995 EDHS which reveals a leveling off of progress, that of neonatal mortality, or death within the first month of life, has declined very little. Consequently, deaths of newborns under one month now comprise close to 50 percent of all infant deaths.

Despite significant gains in child health over the past fifteen years, within Egypt there is great variation in health indicators: infant and overall under five mortality rates are twice as high in rural Upper Egypt (119 and 164, respectively) as in urban Governorates (55 and 68, respectively), and are more than three times higher among mothers with no education. Although the maternal mortality ratio (MMR, women dying of causes related to pregnancy and child birth per 100,000 births) has probably been declining over the last decades, it is still unnecessarily high, 174 per 100,000 live births. This, too, varies greatly within Egypt: the MMR is 217 for Upper Egypt, and within that region, the MMR is 544 in the Governorate of Assiut and 386 in Qena. USAID/Cairo is targeting more resources to these high risk areas of Upper Egypt in an attempt to narrow the gap in regional disparities and improve the health status of the poorest Egyptians.

Tackling these interrelated infant and maternal health problems requires a more integrated approach to providing care and improvements in the quality of care at both the household and facility levels. Comprehensive reproductive health care that includes family planning, life-saving obstetric care, and other essential services will promote the twin objectives of reduced

fertility and improved maternal and child health. The impact is intensified when provided in concert with relevant female education programs. Studies have demonstrated in Egypt that female education is a powerful force in raising levels of contraceptive usage and in improving the health practices of the entire family. Efforts are ongoing among the family planning, health and education teams to integrate activities to the extent feasible.

1. Statement of objective

The Strategic Objective for the Mission's Health Sector program is "Sustainable Improvements in the Health of Women and Children". This objective incorporates the four closely interrelated objectives of the Agency for the Population/Health/Nutrition Sector as presented in the "USAID's Strategic Framework" and utilizes nearly identical approaches to achieving results. Analysis of the Agency's "Key Factors in Population and Health" in relation to Egypt's reproductive health and child survival indicators, justifies the establishment of this strategic objective, particularly with respect to the severe regional disparities in health conditions as discussed below. Despite significant gains in health status over the last twenty years, Egypt still has indicators of child and female health that indicate a critical constraint to sustainable national development within this sector: an under five mortality rate of 80.8 nationally (1993), but 164.4 in rural Upper Egypt (1990); an infant mortality rate of 62.7 (1993) of which half is neonatal mortality; a national average of stunting of children under 5 of 26.1 (1995); a Maternal Mortality Ratio of 174 (1992); and an extremely high prevalence of reproductive morbidities among women, including over fifty percent afflicted with Reproductive Tract Infections (RTI) in one recent study. Although HIV/AIDS prevalence is low, STDs are common and USAID is considering support to national efforts to prevent the further spread of these diseases.

2. Problem analysis

a. Problem to be Addressed

During the late 1970s and early 1980s, USAID assistance to the Government of Egypt resulted in greatly expanded access to health services by the rural and urban poor. Substantial investments were made in training health personnel, upgrading the physical infrastructure, and improving the service delivery system. Since 1983, the focus of the program has been to reduce mortality and illness of infants and children principally through three key interventions: oral rehydration (ORT), an expanded program for immunizations (EPI), and acute respiratory infections (ARI) control. The Egypt child survival program has

been phenomenally successful in improving the health of young children: the infant mortality rate was reduced 43 percent between 1980 and 1990, and the child mortality rate declined 55 percent in the same period. Egypt has made impressive progress in reducing unwanted fertility as well. However, the results of the 1995 EDHS demonstrate that we have reached a plateau in the efforts to reduce child mortality and confirm that our strategy to target neonatal mortality (close to 50% of the IMR) and ensure healthy pregnancies through more complex, integrated interventions is correct.

The causes of maternal and neonatal mortality are overlapping and interrelated, but are largely due to substandard maternal health care or failure of families to seek care when needed. We know that the hundreds of Egyptian women who die each year from pregnancy related causes represent only the "tip of the iceberg", drawing our attention to massive suffering and more deaths related to women's reproductive health.

Rural Egyptians, in particular, suffer from a variety of endemic communicable diseases, of which schistosomiasis and hepatitis B and C are the most significant. The Schistosomiasis Research Program has provided tools to improve treatment and diagnosis of the disease and has collaborated in a world-wide effort to develop a vaccine. The prevalence of schistosomiasis in rural Egypt is now down to almost 10 percent (from 40 percent in the early 1980s) and the intensity of infection and consequent damage due to the disease have been greatly reduced. Nonetheless, further work is required to complete development of key control tools, especially the field testing of vaccine candidates that have been identified. A hepatitis B vaccine has been already incorporated into the ongoing EPI; the coverage is estimated at 89 percent. Hepatitis C has emerged as a major public health challenge. It is far more likely than hepatitis B to remain in the body and cause cirrhosis or fatal liver cancer. Prevalence in rural areas of this deadly disease has been documented as high as 60 percent in adults. Little is known about the modes of transmission, and no cure or vaccine yet exist. It is critical to determine how to prevent the spread of this virulent hepatitis in order to save hundreds of thousands of productive age adults from liver cancer and other consequences of this killer and to plan for incorporation of the vaccine into the EPI once it is developed.

Further progress in achieving the SO is limited by underlying systemic problems that can be divided into five areas: quality, policy, management, financing and participation. These interrelated systemic problems affect the private sector as well as public health programs. (Other indirect contributing factors which play an important role in health status are a high female illiteracy rate, and urban rural disparities in availability of basic services including safe water and modern sewage disposal. These factors are addressed in other Mission SOs.)

An important area of concern is the low quality of services, found throughout the public health care network. Despite extensive physical infrastructure (an MOHP clinic within 2-3 kilometers of each Egyptian domicile), utilization rates are often low because the public's perception of the quality of services received at these facilities is low. Nor is there a system to ensure quality services in the private sector where the quality of care is unknown. Quality constraints stem from a number of factors. Egypt does not have a system of continuing education nor a requirement for recertification of medical professionals. Poor performance can remain unchecked. Once physicians and nurses graduate from medical or nursing school and are assigned to a public sector clinic, they are often on their own. Supervision is minimal or nonexistent, and for those assigned to remote areas, few if any opportunities exist for outside consultations when complicated medical cases arise. Moreover, assignments are skewed leaving urban clinics overstaffed and rural clinics understaffed. The results are profound. The National Maternal Mortality Study reveals that about 60 percent of maternal deaths occur in medical facilities from avoidable causes which could be prevented through better quality services. Most of the neonatal deaths are also preventable if standards for quality care are set, taught and followed by health practitioners.

Egypt spends about 4.7 percent of its national income on health care. This is a moderate, but not low, level of spending for its level of income. Given this level of spending, health status could be better and disparities in provision of basic services reduced by selected policy change. The overall policy environment has at times constrained the pace of implementation of health projects, the options for problem solving, and most importantly, the sustainability of these initiatives. For example, investments in child survival programs are at risk unless the GOE reorients its allocative priorities for spending away from tertiary and secondary facilities to primary health care programs.

The current process of formulating, implementing and evaluating health policies in Egypt needs improvement. An interactive health policy formulation process should involve a broad base of stakeholders, partners, and interest groups. In Egypt the private sector plays a significant role, especially in outpatient treatment of illness. Yet, to date, policy has hardly acknowledged this reality and there are few examples of efforts to make better use of private health care for national health goals. Health services research is required that provides timely and scientific data for decision makers. The Data for Decision Making (DDM) studies, currently supported under the Cost Recovery for Health Project (CRHP), have begun this effort and produced the first reliable health sector-wide information for policy setting. This valuable work is being used to formulate an

overall policy dialogue agenda.

Along with poor quality, there is a common perception of waste and inefficiency in the public sector health services. More cost-effective use of existing resources could significantly improve Egypt's health performance. However, management training for health services is rare, and doctors with little management preparation are generally assigned to management positions on the basis of seniority. Introduction of health services management training that focuses on performance is needed both within existing facilities as well as at university level. Management systems that include routine supervision and data-based monitoring of outcomes are needed at every level and in all sectors.

Egypt has a pluralistic system of financing and provision of health care. There are three main payers in Egypt's health care system: the government (MOHP and other ministries), the public sector (HIO, CCO,and other government-owned institutions) and the private sector. Government spending is low and private spending is relatively high, accounting for well over half of the total expenditure on health care. Household out-of-pocket spending accounts for 55 percent of total national health expenditure. The HIO insures 30 percent of the population, including workers and students, but private health insurance is rare. The MOHP share of spending has declined significantly over the last decade. Yet the MOHP still runs about 60 percent of Egypt's hospital beds and a national network of ambulatory health facilities and public health programs. GOE spending overall is heavily skewed toward tertiary and secondary curative care while the preventive and other primary health programs are seriously underfunded. MOHP service provision is not sustainable given current levels of funding and its internal allocation of resources. Cost recovery experiments for curative treatment are underway; but, as yet have not contributed significantly to covering recurrent costs.

Community participation in the health sector is not common other than as individual consumers and payers of care. Household knowledge of basic health information is generally insufficient to enable families to protect their own health and know when to seek appropriate care. There have been notable successes in informing the public about key health interventions including family planning and ORT and there is ongoing work to expand beyond these areas; however, much remains to be done. Community involvement in the planning and management of health facilities is an unknown phenomenon in most of Egypt; however, here again the CRHP is a leader in introducing the concept of community boards for its hospitals.

b. Customers

The ultimate customers served by SO-7 are Egyptian women of

child-bearing age and children under five. Their health and welfare are influenced by a wide network of intermediate customers from the household level, where they are represented by husbands and the extended family, to the broader community. There they are the neighbors, formal and informal local groups and leaders, including religious leaders, people who can influence public opinion to promote better health. They are the health providers, both public and private, professional nurses, midwives, doctors and pharmacists, and traditional birth attendants and barbers. Intermediate customers share circles of influence in the MOHP, in HIO, and in medical schools. They exist in other ministries such as finance and planning where decisions are made concerning the allocation of scare public resources which affect the sustainability of government health services, and they are in professional medical associations and private voluntary organizations/non-governmental organizations (PVOs/NGOs) whose activities benefit the health sector.

3. Results

a. Results Framework (Detailed Results Framework in Attachment A)

b. Critical Assumptions and Causal Relationships

Sustainable improvements in the health of women and children in Egypt will be realized through the achievement of the four **interrelated** intermediate results outlined in the results framework. Each of these result areas is designed to contribute to the SO, but is mutually dependent on the others. For example, we know that the gains realized in child survival cannot be sustained without attention to the financing of health care. Sustainable programs require strong policy leadership and community understanding and involvement. Egypt will never reach acceptable health indicators and contain the costs of health care without effectively controlling highly prevalent endemic diseases afflicting its population.

Critical assumptions at the SO Level include:

* Continued success in reducing unwanted fertility (SO 6)
* No major epidemics
* Political stability will be maintained

Increased knowledge and improved health behavior in households (IR 5.1) is the first prerequisite for better health status. Although access to health care is nearly universal in Egypt, people often do not seek care early enough, especially not for preventive child health care, prenatal consultations, and problems of pregnancy. Therefore, health seeking behavior is particularly important.

Critical assumptions for Result 5.1 are:

- Trend toward increased NGO involvement and community action will continue
- Television will remain an important medium for development communication

Improving the quality of care provided to women, infants and children is also essential to increase the utilization of these better quality services (IR 5.2) and the central focus of this strategic plan. Egyptian families spend a considerable amount for health care and the GOE finances a wide array of services; USAID's objective is to ensure that these investments are used for cost-effective health interventions and pay off in better health status among the users. This can be accomplished through defining a basic package of essential reproductive and child health services and promoting compliance with clinical and counselling guidelines for quality care by both private and public practitioners. Another important dimension to improving utilization of services is to ensure that health care is culturally acceptable and that providers treat patients and their families respectfully.

Critical assumptions for Result 5.2 are:

- MOHP decentralization policy will be extended to District level
- GOE will continue to procure vaccines, ORS, and other essential inputs for ongoing programs

New tools and approaches are essential to combat endemic and emerging diseases that are afflicting rural populations especially (IR 5.3); these include schistosomiasis which contributes to anemia in women and hepatitis B and C which are highly prevalent in rural communities. As part of a strategy to sustain improvements in health, it makes economic sense to prevent the damage caused by these diseases rather than try to

treat the deadly consequences later in life.

The National Schistosomiasis Control Program is a high priority for the GOE which has entered into loan agreements with the World Bank and African Development Bank for operational costs (such as vehicles and computers). The research activities supported by USAID complement and reinforce the control operations by providing epidemiological data for better targeting and by developing new control tools.

Critical assumptions for Result 5.3 are:

- Major drug resistance will not develop to praziquantel, the only effective treatment for schistosomiasis
- Continued support for control program operations by the GOE and other donors.

Improving the country environment to plan, manage and finance sustainable maternal and child health systems (IR 5.4) is a critical element of our strategy. USAID/Cairo shares the world-wide experience that child survival gains cannot be sustained without a national policy environment that puts a priority on resources for these programs. The technical accomplishments of defining and ensuring provision of quality care to mothers and babies will not be effective without a health sector policy that establishes protection of maternal and child health as a priority, assigns the resources to accomplish it, and capably manages the processes required to ensure an impact.

The capacity to plan, manage, finance and monitor health services is fundamental to ensuring results; weaknesses in these capabilities within the system will be addressed to ensure good performance and sustainability of interventions. Although Egypt spends a considerable portion of its national income on health care (4.7 percent of GNP), the returns to this spending are below levels predicted by international comparisons. A financing strategy is needed that will increase funds for high impact interventions and reorient spending away from high cost/low impact interventions. Targeting of expenditures to governorates with the worst health or lowest incomes as well as to the poorest households is needed to correct imbalances in use of public funds. Better flow of information within the MOHP and with other partners is essential to enable planners to prioritize the use of scarce resources to maximize impact on mothers and children's health. It is important that MOHP leadership remains open to exploration of options for improving the policy framework and targeting the neediest members of society. Experience in the health care reform area in Egypt has shown us the challenging nature of this work; however, we are convinced that we must push ahead if the technical programs we have spent so much effort to create/strengthen are to be sustained.

Critical assumptions for Result 5.4 are:

- Political will to reform health sector persists
- Egyptian population remains willing and able to pay for health services
- GOE commitment to social insurance remains firm

4. Customer Role in Strategic Planning

The primary tool that engages the ultimate customer at the strategic planning level is the Egypt Demographic and Health Survey (EDHS), a nationally representative household survey. The 1992 survey reached 9,864 ever-married women age 15-49. Interviews were also conducted with 2,466 men who were married to women eligible for the EDHS. All areas in Egypt were covered except the thinly populated Frontier Governorates. The primary objective of the EDHS is to provide information on levels and trends in fertility, family planning use, and infant and child mortality and maternal and child health indicators and related male attitudes. The 1995 EDHS, which covered 15,727 households, includes a new women's status module that for the first time will provide information on the important topics of female genital mutilation, domestic violence, financial assets and employment, and related female education issues. EDHS results inform policymakers and administrators assisting in the evaluation of existing programs and in the design of new strategies to improve family planning and health services in Egypt.

As the EDHS is conducted in three to four-year cycles (the 1995 EDHS was conducted in December 1995 and preliminary results will be available in April 1995), other tools are also used to gauge the effectiveness of health interventions. These include KAP (knowledge, attitude and practice) surveys; studies on particular focus areas including maternal mortality, low birth weight, anemia and others; visits to clinics and hospitals to observe conditions and solicit comments from the customers; and community meetings to solicit view of community representatives and members. These approaches have worked well in providing solid links to the views of the ultimate customer. Nevertheless, when challenged to find additional means to improve the directness and frequency of feedback, an innovative tool was proposed and will be developed over the ensuing year. This tool will draw on a network of Egyptian PVOs established by the Alliance for Arab Women, the national coordinator for the Fourth International Women's Conference held in Beijing in September 1995. That network works through 29 focal points spread throughout Egypt under three subdivisions, Upper Egypt, Lower Egypt and Greater Cairo, which reaches about 900 Egyptian PVOs. This network, which is based on a bottom-up approach, will be used to elicit and study customer views on planning, achieving and monitoring needs. Such collaboration will be

beneficial for the Egyptian PVOs as well as to USAID as they will learn from setting up this process of customer consultation.

B. Contributions of Partners to SO Achievement

1. Overview:

The SO Team is defining a Partner as an organization, an Intermediate Customer (IC) or Customer Representative (CR)with which USAID works cooperatively to achieve mutually agreed upon objectives and Intermediate Results (IRs) and to secure customer participation.

2. Identification of Partners

The following list of partners is indicative and not exhaustive:

Government of Egypt (GOE): Ministry of Health and Population (MOHP); Public Sector Organizations which include: Health Insurance Organization (HIO), Cairo Curative Organizations (CCO), Teaching Hospital Organization (THO); Other Ministries which include: Ministry of Education (MOE), Ministry of Planning (MOP), Ministry of Economy and International Cooperation (MEIC), Ministry of Information (MOI), Ministry of Finance (MOF).

NGOs & PVOs: Professional Medical Associations; International PVO's; Other Egyptian NGO's.

Private Organizations: CGC and its network of commercial banks; Private Hospitals; Pharmaceutical companies; Private Health Insurance Organizations.

Donors: Multilateral (WHO, UNICEF, UNFPA, World Bank, EC); Bilateral (JICA, DANIDA, FINNIDA, Italian Cooperation, Dutch AID, SIDA); Foundations.

Mass Media: TV & Radio; Press.

3. Role and Contributions of GOE

The GOE controls and regulates the work of all health care organizations and facilities and all service providers. The GOE is also a major financier and service provider. It is responsible for regulating the production, importation, and pricing of all pharmaceuticals and medical supplies. Finally, it is responsible for health and population policy formulation.

The MOHP provides a network of more than 3,700 primary, secondary and tertiary health care facilities distributed nationwide through which maternal and child health services are being provided. HIO insures about 30% of the population

throughout the country, about half of whom receive services through HIO's own facilities and the rest through contracted services. The GOE employs about 80% of health care providers in Egypt, although many also work in private practice. The health budget of the GOE is estimated at LE 2.6 billion for 1994/95, of which the MOHP receives LE 1.4 billion. The HIO, CCO and Teaching Hospitals (THO) receive the balance.

The MOE administers medical schools within its universities and a large number of nursing schools in addition to allied health services. Any improvement in the quality of health care for women and children will require a revision in the curricula and teaching methodology of these institutions to reflect the state-of-the-art in maternal and child health and more practical primary health care training.

4. Role and Contributions of NGOs & PVOs

The role of NGOs and PVOs is important particularly in areas of high unmet need for maternal and child health services and where geographic targeting is required. International and Egyptian NGOs and PVOs offer health services and other related community development services or provide support and advocacy for a better policy environment. They have service facilities, service providers, community recognition and support, and various sources of funds from USAID and other donors. Many mosques and churches have health clinics which are very popular with low and middle income groups who find them more affordable than the commercial private sector and better quality than the public sector.

There are many professional medical associations, of which the most important is the Medical Syndicate that has a membership of more than 100,000 physicians. Improving the quality of health care and setting standards of practice will require the involvement of this and similar professional associations.

5. Role and Contribution of Private Sector

The private sector provides more than 80% of the outpatient services in Egypt. The contribution of the private sector is the network of private clinics and hospitals, pharmacies, and the pharmaceutical companies.

6. Role and Contribution of Donors

The contribution of donors is in the form of direct financial support, technical assistance, commodities, and training. USAID is by far the largest and most active donor in the health field. UNICEF and WHO are also major players. Active bilateral donor

agencies include most European countries and the Japanese. Most bilateral donor projects tend to be primary health care activities involving one or more districts. The World Bank's involvement has been limited to schistosomiasis control program support; however, they are exploring future involvement in health sector reform with the GOE. The total amount provided by other donors to this sector is estimated at about $22 million a year.

7. Role and Contribution of Mass Media

About 82 per cent of households possess TV and watch it daily and more than 95 per cent of the population has access to mass media. The media can be used to increase awareness, change attitudes and behavior, combat rumors, and disseminate health information. The contributions of the mass media are represented in its public radio, two nationwide and six local TV stations, and a very wide range of local newspapers.

C. Illustrative Approaches

1. Approaches

Several interrelated approaches are required for achievement of IR 5.1, "**Increased Knowledge and Improved Health Behavior of Households**". The accomplishment of this result requires programmatic impact on the following household behaviors:

- Nutritional practices (with emphasis on breast feeding).
- Prevention of common childhood diseases.
- Hygienic practices (personal, environmental).
- Health seeking behavior for sick children (emphasis on ARI and diarrhea).
- Pregnant women seek prenatal care.
- Health seeking behavior of women with maternal and newborn complications.
- Immunization of children under one and pregnant women.
- Birth spacing practices, particularly among young couples

To impact on these behaviors, an Information, Education and Communication (IEC) program should be implemented which includes a mix of mass media messages reinforced through "face-to face" communication by health care providers and community change agents:

- Identification and standardization of consistent messages related to the behaviors listed above.
- Design and implementation of national mass media campaign using television, radio and other audio visual media.
- Community groups, NGOs, GOE agencies, educators and health providers organized and engaged in IEC activities.
- Health providers give reinforcement to households

demonstrating good health behavior.

IR No. 5.2, "**Improve Quality and Increased Utilization of Maternal,Perinatal and Child Health Services"** will involve improving the quality of reproductive and child health services with special emphasis in Upper Egypt governorates which are considered high risk areas. It will also ensure the sustainability of the established Child Survival programs which include the EPI, CDD, ARI and Neonatal Care Programs. This result will address major gaps in the quality of health services through these approaches:

- Establish and define basic package of essential reproductive, perinatal and child health services. (This package will include prenatal, delivery, and postnatal care; neonatal care; breastfeeding promotion; child preventive services; sick child case management; reproductive health services including family planning, reproductive tract infections and education on harmful practices; 40th day integrated visit for mother and child; counselling and health education on all the above.)
- Training in standards of basic package of essential services included in medical and nursing curricula.
- Pre/in-service training system designed to disseminate standards and develop competency-based skills to public and private providers.
- Pu Public and Private providers in partnership with communities in high risk governorates to plan and manage essential services in districts.
- Management capacity enhanced at governorate and district level to plan and manage essential services.
- Decentralized cost recovery mechanism implemented to ensure resource availability.
- Monitoring system in place to track utilization and impact and provide feedback.
- District referral system defined and operational and is known to the community.
- EPI, CDD, ARI and Neonatal program institutionalized within MOHP and integrated into the basic package of essential services.

Within IR 5.3, "**New Tools and Approaches to Combat Selected Endemic and Emerging Diseases Developed and Disseminated**", USAID's approach has been to enhance local research capability to develop tools, including data, needed to combat selected priority diseases. Much of the research capability developed for Schistosomiasis work is readily applicable to other emerging or reemerging diseases.
In schistosomiasis, work has included:

- Formulation of a research agenda directed toward the development of specific control tools including vaccine

candidates

- A competitive grants program linking Egyptian and American investigators to develop the tools
- Establishment of key systems and institutions such as a Praziquantel resistance surveillance system and the Egyptian Reference Diagnostic Laboratory.

For other endemic diseases, approaches include:

- Support of studies to determine modes of transmission and plan control measures

IR 5.4 involves a set of approaches designed to achieve "**Improved Environment to Plan, Manage and Finance Sustained Maternal and Child Health Systems**". These include capacity building in the MOHP and other organizations as well as promoting a broad-based dialogue on health sector policy that involves a wide range of stakeholders. The role of the MOHP is being redefined to give greater attention to health promotion and prevention, regulation, financing and assurance of quality of care. A careful analysis of the overall curative sector will be done to determine how curative services should be organized and delivered and how to move the MOHP and possibly HIO out of direct provision of hospital based care. Specifically, the approaches include:

- Clear articulation of policies, priorities and plans
- Promoting an equitable and financially viable expansion of social insurance coverage.
- Assisting in the development and implementation of a national quality assurance system.
- Supporting development and replication of innovative private sector health service delivery and financing models.
- Improving systems for the collection, analysis and use of health information; and
- Improving personnel management, skills and in-country training programs and institutions.

2. Customer Role in Achieving

Achieving starts at the local community. It has been found impractical to expect the central level of the MOHP to have the means to assure quality services and to supervise and manage the health providers at every health care facility in the country. Whether through the public or private sector, the quality of health care provided locally in Egypt remains inadequate to prevent illness and avoidable deaths. Responsibility for quality control and supervision must shift to the local community to encourage wider participation, the marshalling of local resources and to take advantage of the higher levels of

accountability. To encourage that shift, greater emphasis will be placed on developing Egyptian NGO capacity in the health sector and on mass media campaigns.

D. Plan for Sustainability Achievement

Sustainability is built into each of the primary intermediate results under this strategic objective. For example, the first intermediate result concerns changes in knowledge, attitudes, and behavior at the household and community levels. Once established and their positive results felt, such changes tend to be self-replicating. The second intermediate result area aims to improve the quality of basic health services for women and children based on low-cost, proven health technologies. This will strengthen the cost-effectiveness of and demand for such services, which in turn enhances their sustainability. In fact, intensive child survival efforts to date have brought about sustained positive trends in maternal and child health throughout most of Egypt. Therefore, USAID resources for the first two intermediate results will now be concentrated on the remaining governorates with lagging health indicators in order to achieve and sustain the same results there.

A concrete example of the GOE's commitment to sustain critical child survival initiatives grew out of the Mission's policy dialogue in this sector. In the past, the procurement of vaccines for the Expanded Program of Immunization (EPI) relied too heavily on donor funding. To ensure the long-term EPI sustainability, the GOE has created a separate line item for vaccines in their recurring cost operating budget. This major breakthrough demonstrates the viability of policy dialogue based on sound, objective assessments. Greater emphasis will be placed on achieving sector improvements through policy reform in the future.

The third and fourth intermediate results concern the sustainability of the overall health system, a major constraint for both the effectiveness and sustainability of maternal and child health services. Moreover, USAID's definition of sustainable development emphasizes not only the achievement of certain health targets, but also the capacity of the society and its institutions to meet new challenges. The Egyptian health sector faces growing challenges and increasingly suffers from missed opportunities to get more impact with the available resources. The MOHP and related agencies, such as the HIO, need stronger capacity and systems for gathering and analyzing information, setting priorities, systematically defining strategic options, and managing for results.

Activities directed at the third and fourth intermediate results will help to provide the information, training, and experience needed to produce and support the next generation of managers. The financial viability of the health sector will also be

addressed directly through efforts to improve cost recovery from those who can afford to pay, target public resources more effectively to the poor, and make better use of the private health sector.

Other principles already being applied to improve sustainability include engaging existing entities rather than creating new, donor-dependent project units; designing activities which can operate within host country resource constraints; eliminating GOE dependence on USAID funding for operating budgets; and placing increased emphasis on needed policy reforms.

Lastly, it should be noted that other Mission SOs help to sustain health improvements. For example, increased access to potable water and sewage systems eliminates a major cause of childhood diarrhea and, thus, reduces the need for ORT among substantial segments of the population. In turn, improved health reinforces other SOs such as education, and more efficient health care financing has economic benefits, as well.

E. Performance Monitoring Plan

1. Overview

Indicators have been identified for the Strategic Objective as well as each IR. The Performance Monitoring System involves the tracking of these indicators by measuring their values over time and comparing these values to their respective targets. The health sector is relatively fortunate in having data available from a wide variety of sources, notably the Egypt Demographic and Health Survey (EDHS), which is explained more fully on page 11. At the SO level, the two indicators identified are measured through different studies. Under-five mortality is measured through the EDHS mentioned above. The maternal mortality ratio baseline data are available from the National Maternal Mortality Study conducted in 1992-93. This study will be repeated in future to provide follow up data to measure improvements.

2. Indicators

Indicators have been identified which meet the following criteria: measurable, unidimensional, practical, reliable, valid and expressed numerically. To the extent possible, such indicators are quantitative in nature, that is, they can be directly assessed through primary measurement of objectively verifiable phenomenon. There are times, however, due to the type of results to be obtained, that indicators have been identified that are qualitative in nature. Such indicators can meet the criteria mentioned above, but may need to be indirectly measured. Data capture becomes an important constraint with many of the indicators. Service utilization statistics would be most useful for many of the indicators (e.g., 5.2a: Percent of women attending 4+ prenatal visits), but GOE/MOHP utilization statistics are often questionable in terms of validity and reliability -- further compounding this is the lack of a systematic method of capturing utilization data from the private sector. This situation necessitates the allocation of sufficient resources to conduct surveys such as the EDHS. GOE/MOHP data tends to be more dependable in vertical program areas, such as EPI or schistosomiasis control. Another constraint is in dealing with indicators that are designed to measure consolidation phase achievements, as in schistosomiasis control. In this situation, the margin of error can be larger than the final few percentage points in improvement that are targeted. In this case, the scope of the indicator will be reduced to measure improvement only in high prevalence areas, where larger reductions are anticipated than in areas where considerable improvement has already been realized. Baseline data present a constraint with some indicators, especially in new areas. Such data are ate times unavailable, or are questionable. Establishment of baseline data will be a priority for several indicators (e.g., 5.4.6: Inpatient care provided in

private facilities). Please see Annex A for details about each indicator.

3. Targets

Targets are developed for each Result through the considered judgement of the Strategic Objective Team and represent the level of achievement that should be expected by a specific future date. The method of stating the target depends on the method of measurement of the indicator for the respective Result. As with indicators, targets are expressed numerically. Please see Annex A for details about each target.

4. Customer Role in Monitoring

To reach women and children, particularly those in Upper Egypt, USAID is extending efforts to district-level health offices to improve the reliability of their health data collected and their system of reporting. Surveys and studies will complement that data including a repeat of the National Maternal Mortality Study. The prime contractor will also convene workshops to examine and disseminate lessons learned from models (successful and otherwise) that feed into the health strategy.

III. Resource Requirements

A. Program Resource Requirements

An average annual obligation of $35 million is anticipated for this SO. Actual requirements will be defined once Results Package Teams are formulated.

B. Staff Requirements

The core SO Team consists of three health officers, one population officer, two financial management specialists, one economist, one WID advisor, one PDS representative, and a team leader. In addition, there are two virtual team members from G/PHN. The extended SO team includes the team leaders of each results package, e.g. four health officers, as well as a legal advisor, a contracts officer, an accountant, and a training specialist. HRDC/H staffing includes four USDH, four FSN Project Managers, one US PSC, one Project Management Assistant, and two Secretaries.

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Attachment A

Results Framework

STRATEGIC OBJECTIVE # 5
Sustainable Improvements in Health of Women and Children

RESULT # 5.3
New Tools & Approaches to Combat Selected Endemic and Emerging Diseases Developed & Disseminated

Relevant Indicators:

16.3 Prevalence of schistosomiasis.

indigenous

priority

RESULT # 5.3.1
Tools for schistosomiasis control developed and applied

RESULT# 5.3.1.1
Diagnostic tools

RESULT # 5.3.1.2
Vaccine development

RESULT # 5.3.1.3
Treatment methods

RESULT # 5.3.1.4
Host snail control

RESULT # 5.3.1.5
Epidemiological data for targeting control program resources

RESULT # 5.3.2
Modes of transmission and potential preventive measures from hepatitis C identified

RESULT# 5.3.2.1
Studies completed

RESULT# 5.3.2.2
Preliminary findings reviewed for program implications

RESULT# 5.3.2.3
Final findings and recommendations reviewed to determine next steps

RESULT # 5.3.3
Sustained capacity to carry out research on diseases

RESULT # 5.3.1.6
Control strategies
using new tools

STRATEGIC OBJECTIVE # 5

Sustainable Improvements in Health of Women and Children

RESULT # 5.3

New Tools & Approaches to Combat Selected Endemic and Emerging Diseases Developed & Disseminated

Relevant Indicators:
16.3 Prevalence of schistosomiasis

RESULT # 5.3.1

Tools for schistosomiasis control developed and

RESULT# 5.3.1.1
Diagnostic tools

RESULT # 5.3.1.2
Vaccine development

RESULT # 5.3.1.3
Treatment methods

RESULT # 5.3.1.4
Host snail control

RESULT # 5.3.1.5
Epidemiological data for targeting control program resources

RESULT # 5.3.1.6
Control strategies using new tools

RESULT # 5.3.2

Sustained indigenous Modes of transmission and applied potential preventive measures from hepatitis C identified

RESULT# 5.3.2.1
Studies completed

RESULT# 5.3.2.2
Preliminary findings reviewed for program implications

RESULT# 5.3.2.3
Final findings and recommendations reviewed to determine next steps

RESULT # 5.3.3

capacity to carry out research on priority diseases

RESULT FRAMEWORK SO5

GOAL
Broad Based Sustainable Development
with Improved Quality of Life

SUB-GOAL
Reducing Population Growth and
Improving Health

STRATEGIC OBJECTIVE # 5
Sustainable Improvements in the Health
of Women and Children

INDICATORS
5.a Under Five Mortality Rate

5.b Infant Mortality Rate

5.c Maternal Mortality Ratio

RESULT # 5.1
Improve Quality and Increase
Utilization of Maternal, Perinatal
and Child Health Services

RESULT # 5.1.1
Quality of Essential Maternal,
Perinatal and Child (MP+C)
Health Services Improved

INDICATOR 5.1a
Case fatality
rate for
obstetric emergencies

RESULT # 5.1.2
Districts
Implementing Essential
MP+C Services in Target
Governorates

INDICATOR 5.1b
Neo-natal mortality rate

RESULT # 5.1.3
Established National
CS Programs Sustained

RESULT # 5.1.4
Increased Knowledge and
Improved Health Behavior in
Households

RESULT # 5.2
New Tools & Approaches
to Combat Selected Endemic and Emerging
Diseases Developed & Disseminated

RESULT # 5.2.1
Tools for schistosomiasis
control developed
and applied

INDICATOR 5.2
Prevalence
of Schistosomiasis

RESULT # 5.2.2
Modes of
transmission of and potential
preventive measures for
hepatitis C identified

RESULT # 5.2.3
Sustained indigenous
capacity to carry out
research on priority
diseases

RESULT # 5.3
Improved Environment to Plan,
Manage and Finance Sustained
Maternal & Child Health Systems

RESULT # 5.3.1
Clearly articulated
policy

RESULT # 5.3.3
Equitable and financially
viable expansion of social

RESULT # 5.3.5
System to collect, analyze,
and facilitate use of

RESULT # 5.3.7
Enhanced capacity to plan
and manage public health

INDICATOR 5.3
Percent of
Health & Population

priorities and plans

finance coverage

health information

program

funding allocated for primary & preventive services

RESULT # 5.3.2
Rationalized MOH curative care services program

RESULT # 5.3.4
National quality assurance system

RESULT # 5.3.6
Increased private sector provision & financing of cost effective health care

STRATEGIC OBJECTIVE # 5

Sustainable Improvement in
Health of Women and Children

RESULT # 5.1

Improve Quality and Increase

Utilization of Maternal, Perinatal
and Child Health Services

RESULT # 5.1.1
Quality of Essential Maternal,
Perinatal and Child (MP+C)
Health Services Improved

RESULT # 5.1.1.1
Basic package of
essential services establ-
-ished & standards
defined

RESULT # 5.1.1.2
Training in standards
included in medical and
nursing curricula and
clinical practice

RESULT # 5.1.1.3
Pre/in-service training system
designed to disseminate
standards to public and
private providers

RESULT # 5.1.2
Districts
Implementing Essential
MP+C Services in Target
Governorates

RESULT # 5.1.2.1
Public & private providers
in partnership with committees
to plan & manage district
essential service package

RESULT # 5.1.2.2
Management capacity
enhanced at governorate &
district level to plan & manage
essential services

RESULT # 5.1.2.3
Key public & private
service providers
trained

RESULT # 5.1.2.4
Decentralized cost recovery
mechanism implemented
to ensure resource availability

RESULT # 5.1.2.5
Monitoring system
in place to track
utilization & impact &
provide feedback

RESULT # 5.1.2.6
Teams in facilities taking
corrective action

RESULT # 5.1.3
Established National
CS Program Sustained

RESULT # 5.1.4
Increased Knowledge and
Improved Health Behavior in
Households

to improve quality

RESULT # 5.1.2.7
District referral system
defined & operationalized

ANNEX A

Performance Monitoring Plan

ANNEX B

Customer Service Plan Table

EGYPT **Approved: June 1996**

STRATEGIC OBJECTIVE 5: Sustainable Improvements in the Health of Women and Children

Indicator: Under Five Mortality Rate

Unit of Measure: Annual number of deaths of children

Source: Egyptian Demographic Health Survey (EDHS)

Comments: Prior Reference Year 1983: 139

Year	Planned	Actual
1993(B)		80.6*
1994		NA
1995		NA
1996	NA	NA
1997	76*	
1998	NA	
1999	NA	
2000	NA	
2001(T)	73*	

Indicator: Infant Mortality Rate

Unit of Measure: Annual number of deaths of infants

Source: EDHS

Comments: Prior Reference Year 1983: 97

1993(B)		62.6*
1994		NA
1995		NA
1996		NA
1997	55*	
1998	NA	
1999	NA	
2000	NA	
2001(T)	53*	

Indicator: Maternal Mortality/National Ratio

Unit of Measure: Annual number of maternal deaths per

Source: Maternal Mortality Study 1992/93

1992(B)		174
1993		NA
1994		NA

	Year	Planned	Actual
	1995	170	NA
	1996	165	NA
	1997	NA	
	1998	155	
	1999	NA	
	2000	NA	
	2001(T)	139	

Result No. 5.1: Improve Quality and Increase Utilization of Maternal, Perinatal and Child Health

Indicator: Case Fatality Rate for Obstetric Emergencies

Unit of Measure: Case fatality rate for women referred for			
	1992/3(B)		47
Source: National Maternal Mortality Study 1992/93*	1995		NA
Comments:	1996		NA
	1997	NA	
	1998	43*	
	1999	41*	
	2000	38*	
	2001(T)	35*	

Indicator: Neonatal Mortality Rate

Unit of Measure: Annual number of deaths of infants			
	1990(B)*		47
Source: EDHS; MOHP statistics	1993(B)**		30
Comments:	1994		NA
	1995		NA
	1996	30/47***	NA
	1997	29/45	
	1998	45	
	1999	44	
	2000	43	
	2001(T)	42	

Result No. 5.1.1: Quality of Essential Maternal Perinatal and Child (MP+C) Health Services Improved

Indicator: Prenatal Care/National

Unit of Measure: % of pregnant women receiving four or

Source: EDHS; MOHP Statistics

Comments: Prior Reference Year 1990: 22%

Year	Planned	Actual
1993(B)		28
1994		NA
1995		NA
1996	NA	NA
1997	40	
1998	45*	
1999	52*	
2000	60*	
2001(T)	70	

Indicator: Immunization Coverage

Unit of Measure: % of living children between 12 and 23

Source: EDHS; MOHP statistics

Comments: * As data differs between EDHS and MOHP

1992(B)*		67.4
1993		NA
1994(B)*		87
1995		79/91
1996	NA/90	NA/NA
1997	NA/90	
1998	NA/90	
1999	NA/90	
2000	NA/90	
2001(T)	90/90	

Result No. 5.1.2: Implementing Essential MP + C Services in Target Governorates

Indicator: Districts implementing essential MP+C Services

Unit of Measure: Number of districts implementing MP+C

Source: Project Data

Comments: Figures are cumulative.

1996 (B)		0
1997	5	
1998	15	
1999	30	
2000	50	
2001 (T)	65	

Result No. 5.1.3: Established National Child Survival Programs Sustained

Indicator: Indigenous Polio Cases

Unit of Measure: Number of confirmed indigenous polio

Source: MOHP surveillance systems

Comments: Prior Reference Year 1988: 550

Year	Planned	Actual
1994(B)		120
1995	60	71
1996	30	70*
1997	20	
1998	0	
1999	0	
2000	0	
2001(T)	0	

Indicator: Neonatal Tetanus Cases

Unit of Measure: Number of neonatal tetanus cases

Source: MOHP surveillance systems

Comments: Prior Reference Year 1984: 7,256

1994(B)		993
1995	600	790
1996	500	500
1997	400	
1998	300	
1999	250	
2000	225	
2001(T)	200	

Result No. 5.1.4: Increased Knowledge and Improved Health Behavior in Households

Indicator: Percent of infants exclusively breastfed for the first 4-5 mos. of life

Unit of Measure: % - same as above

Source: EDHS; MOHP statistics

Comments: Prior Reference Year 1992: 28.6%

1994(B)		NA
1995	NA	30.7
1996	NA	NA
1997	NA	
1998	45*	
1999	55*	
2000	65*	
2000	65*	
2001 (T)	75	

Result No. 5.2: New Tools & Approaches to Combat Selected Endemic and Emerging Diseases

Indicator: Prevalence of schistosomiasis

Unit of Measure: % of school children infected with S.

Sources: Epidemiological surveillance by the National

Comments: Prior Reference Year 1988: 16.4

Year	Planned	Actual
1994(B)		13.8
1995	15	14.5
1996	12	NA*
1997	10	
1998	8	
1999	7	
2000	6	
2001(T)	5	

Result No. 5.2.1: Tools for schistosomiasis control developed and applied

Indicator: Schistosomiasis control tools

Unit of Measure: Number of control tools, both applied

Source: Project Reports

Comments: Figures are cumulative.

1994(B)		5
1995	5	6
1996	6	7
1997	7	
1998	8	
1999	8	
2000	9	
2001(T)	9	

Result No. 5.2.2: Modes of Transmission of and Potential Preventive Measures for Hepatitis C

Indicator: HCV transmission modes determined.

Unit of Measure: Results of 5-year field research program

Source: Grantee Reports

Comments:

Year	Planned	Actual
1995(B)		NA
1996	BM #1	BM #1
1997	BM #2	
1998	BM #3	
1999	BM #4	
2000	BM #5	
2001(T)	BM #T	

Result No. 5.2.3: Sustained Indigenous Capacity to Carry Out Research on Priority Diseases

Indicator: Egyptian Reference Diagnostic Laboratory (ERDL)

Unit of Measure: ERDL continues to support key

Source: Project reports and site visits

Comments:

1993(B)		BM #1
1994		BM #2
1995		BM #3
1995		BM #4
1996		BM #5
1997	BM #6	
1998	BM #7	
1999	BM #8	
2000	BM #9	
2001(T)	BM #T	

Result No. 5.3: Improved Environment to Plan, Manage and Finance Sustained Maternal & Child

Indicator: Percent annual increase in MOHP funding allocated for primary and preventive services

Unit of Measure: % of MOHP funding allocated for

Source: MOHP Budget Tracking System

Comments:

Year	Planned	Actual
1995		NA
1996		NA
1997	10	
1998	20	
1999		
2000	40	
2001(T)	50	

Result No. 5.3.1: Clearly Articulated Policy Priorities and Plans

Indicator: Policy measures and benchmarks established and agreed to with MOHP

Unit of Measure: Yes or No

Source: Joint MOHP/USAID MOU

Comments:

1997(B)	Yes	
1998	Yes	
1999	Yes	
2000	Yes	
2001(T)	Yes	

Result No. 5.3.2: Rationalized MOHP Curative Care Services Program

Indicator: Number of MOHP hospitals/polyclinics operating as cost recovery (CR) facilities

Unit of Measure: No. of MOHP hospitals/clinics operating

Source: MOHP Budget Tracking system

Comments: Figures are cumulative.

Year	Planned	Actual
1988(B)		0*
1989		0
1990		0
1991		0
1992		0
1993		0
1994		0
1995		5
1996	10	5
1997	20	
1998	30	
1999	50	
2000	85	
2001(T)	100	

Result No. 5.3.3: Equitable and Financially Viable Expansion of Social Finance Coverage

Indicator: Percent of Egyptians covered under social insurance

Unit of Measure: % of Egyptians covered under social

Source: HIO beneficiary registration reports

Comments:

1994(B)		30
1995	30	32
1996	30	32
1997	30	
1998	30	
1999	40	
2000	40	
2001(T)	50	

Result No. 5.3.4: National Quality Assurance System

Indicator: Number. of hospitals with quality assurance committees and regular reporting

Unit of Measure: No. of hospitals with functioning quality

Source: MOHP management reports

Comments: Figures are cumulative.

Year	Planned	Actual
1995(B)	1	1
1996	5	5
1997	25	
1998	100	
1999	100	
2000	200	
2001(T)	300	

Result No. 5.3.5: System to Collect, Analyze, and Facilitate Use of Health Information

Indicator: Number of governorates with operational MIS and submitting required reports and data

Unit of Measure: No. of governorates with operational

Source: MOHP management reports

Comments: Figures are cumulative.

1994(B)		0
1995	7	7
1996	7	7
1997	11	
1998	15	
1999	27	
2000	27	
2001(T)	27	

Result No. 5.3.6: Increased Private Sector Provision & Financing of Cost Effective Health Care

Indicator: Inpatient care provided in private facilities

Unit of Measure: % of inpatient care provided in private

Source: MOHP Management Reports

Comments:

Year	Planned	Actual
1995(B)		10
1996	10	15
1997	10	
1998	15	
1999	15	
2000	20	
2001(T)	25	

Result No. 5.3.7: Enhanced Capacity to Plan and Mange Public Health Program

Indicator: Academic training departures

Unit of Measure: Number of academic training departures

Source: PTMS

Comments: Figures are cumulative)

1994(B)		0
1995		2
1996	2	4
1997	10	
1998	20	
1999	30	
2000	40	
2001(T)	50	

SUBGOAL 3:
Reduced Population Growth and Improved Health

At the subgoal level, the Mission is monitoring annual changes in life expectancy, population size and the population growth rate, indicators which appeared at the Agency Goal 3 level. Life expectancy remains unchanged at 62 for men and 65 for women. Preliminary figures show Egypt's population increased from 59 million in 1995 to 61.4 million in 1996 with the growth rate remaining at 2.2%.

Another area being monitored is integration at the Ministry of Health and Population (MOHP). Although the merger of the two ministries brought MCH and FP services under one ministry last year, separate administrative units will continue to manage those services. It is important to note, however, that prior to the merger, service delivery was never separate. Service delivery in the field will continue to combine MCH and FP. USAID will promote greater linkage in health and family planning services through joint information, education and communication (IE&C) activities, combined management information system activities, coordinated training of MOHP management and technical staff, development of cross-referral protocols, joint work in medical schools, and joint work on policy dialogue. As institutional change evolves, USAID will have a role in facilitating that process through technical assistance and sector program support.

SO 4: Reduced Fertility

1. Performance Analysis:

Egypt achieved spectacular results in reducing the fertility rate from 6.7 children per family in the mid-1960s to 3.63 in 1995, averting seven million births. Despite the success of the program, the 1995 Egypt Demographic and Health Survey (EDHS) demonstrated that a plateau was reached in the use of family planning services in the early 1990s which undermined projections which had maintained a higher trend. This is of major concern. The current plateau is caused by population momentum, high discontinuation rates, a drop-off in private sector family planning marketing efforts, and some disarray and loss of initiative in family planning by the GOE.

IR 4.1.1, the percentage of GOE FP clinics with sustained quality standards, shows a shortfall (0% in lieu of 5% planned) in 1995, representing GOE FY 1995, and in 1996 (6% in lieu of 15% planned). This was due to (1) a delay in mobilizing institutional support during the start-up period and (2) the requirement that a clinic maintain the specified quality standards for at least two quarters to qualify for Gold Star status. In 1996, an additional 3% or 144 more clinics had achieved the quality standards for one quarter. This effort is now on track.

IR 4.1.2 shows that demand for family planning services dropped from 69% in 1992 to 63.9% in 1995. Two explanations seem to account for that drop: (1) widespread misinformation about the side effects of contraceptives that led some women to discontinue contraception, and (2) the termination of USAID-donated contraceptives to

the private sector that contributed to a decline in private sector service provision.

IR 4.2 unit of measure: GOE contribution to total cost of family planning program: The large jump in expenditures in GOE FY 1994/95 represent inflated costs resulting from the International Conference on Population Development (ICPD).

IR 4.2.1, reporting on financial self-sufficiency of the family planning systems, shows that the percent of client payments for family planning/Couple Years Protection (CYPs) services fell short of planning levels in 1995 (1996 data are not yet available), 8.3%, down from 13% planned. In fact, actual client payments had increased from the previous year; however, since total GOE expenditures (the denominator) was inflated due to ICPD expenditures (see 4.2), the percentage of client payments to total expenditures shows a decrease.

IR 4.2.2, the training program for mid-level managers produced better than expected results, reaching 58% of the pool as opposed to the planning figure of 45% thanks to excellent support from the MOHP and the contractor.

2. Expected Progress Through FY 1999 and Management Actions:

Fertility is expected to continue to decline through 1999 and beyond, although the rate of decline is slowing. Population momentum; the increasing difficulty of reaching more remote, poor, and traditional segments of the population; and the maturing of the Egyptian national population program contribute to the slowing of fertility reduction. To some extent, these factors should be offset by planned more aggressive private sector marketing of family planning services, new NGO initiatives, and improved quality of public sector service. USAID recently launched a new initiative to stimulate greater private sector involvement through training and advertising/marketing campaigns for commercial and NGO providers and by resuming the supply of donated contraceptive pills to NGOs. IE&C activities and media measures will be re-invigorated to overcome misinformation and to encourage new acceptors. The new results package, Population/Family Planning IV, will emphasize the importance of finding new approaches to encourage greater momentum.

Another important step will be to ensure progress is accurately tracked. Since the Total Fertility Rate, the direct indicator of fertility, is only measured every fifth year, a proxy indicator called the "general fertility rate" (GFR) is used for intermediate years. The GFR masked the plateau because it is strongly influenced by the age structure of the population. Progress was distorted when a large cohort of young women moved into the equation. An annual survey is being developed to replace three proxies, the GFR at the SO level, the synthetic contraceptive prevalence rate (for IR 4.1), and CYPs attributable to more effective methods (for IR 4.1.1), to provide more useful annual backup for the EDHS data.

SO 5: Sustainable Improvements in the Health of Women and Children

1. Performance Analysis:

Egypt has made impressive strides in increasing life expectancy and reducing child mortality in recent decades. Overall progress continues to be on track. The most important health status gains have been in terms of prevalent childhood diseases, such as the immunizable diseases and diarrheas. The infant mortality rate (IMR), which is one of the best indicators of overall well being of a society, requires some clarification concerning the trend line. The monitoring plan in the last R4 gave an IMR of 61.5 for the reference year 1990 and 61.0 for 1995/actual, which may have suggested a plateau had been reached. In fact 61.0 did not represent 1995, the year the EDHS-95 survey was completed. The IMR should have been stated as the mid-year point of the survey, i.e., 1993. An explanatory note has been added to the tables to make that distinction clear. Another distinction concerns the time frame. Mortality rates are measured over a long period because change is not always linear. The IMR dropped 35 percent, from 97/1000 to 63/1000 in the past 14 years. The data has been reviewed and the Mission has concluded that, with the targeting envisioned, the downward trend will continue with 55/1000 projected for 1997.

Quality child health services are being sustained and extended. Fully immunized children reached 79% in the EDHS-95 (5.1.1). Polio cases fell from 625 in 1991 to 71 in 1996; neonatal tetanus is now below the recommended targeted level for elimination (5.1.3). Performance is on track with endemic and emerging diseases (5.2) including schistosomiasis work as monitored in the sentinel regional, Kafr El Sheik; the Egyptian Reference Diagnostic Laboratory (one of three laboratories worldwide selected by WHO to perform in vitro tests of candidate antigens for schistosomiasis); field work under the hepatitis C virus grant; and the study of the prevalence of sexually transmitted diseases to identify groups who would also be potential "core transmitters" for HIV/AIDS.

Considerable progress has been made on the agenda of policy and institutional reforms (5.3.1) to be undertaken by the MOHP and related health agencies. The draft policy matrix, identifying planned implementation strategies and targets, has been prepared and final negotiations toward the development of indicators and benchmarks for the first tranche disbursement are underway in the Mission for the new Health Sector Policy Reform Program (See Annex D).

The cost recovery (CR) conversion model has been simplified and site surveys completed for ten new hospitals (5.3.2) which will make up for some lost momentum in 1996 when projections for new CR facilities were higher than actuals. Quality assurance (QA) programs have been established in the four remaining facilities and the MOHP plans to establish a QA unit at the central level. Implementation of the new Health Insurance Organization automated management information system is proceeding on schedule (5.3.3).

2. Expected Progress Through FY 1999 and Management Actions:

Despite the gains, deaths among young children remain unacceptably high with an IMR of 62.6 and total under five mortality rate of 80.6 per 1,000 live births (1995). The

EDHS-95 confirms the correctness of the approach in the SO 5 strategy to further reduce the IMR by targeting neonatal mortality, representing 48% of the IMR, and Upper Egypt, which has had an IMR of 97.7/1000 for the last ten years compared to 42.9/1000 for urban governorates and 60.9/1000 for Lower Egypt. The health problems that characterize Egypt as a whole are particularly severe in Upper Egypt where population density is high and where health services are greatly in need of improvement. The Healthy Mother/Healthy Child project targets district-level interventions in Upper Egypt. The first steps have been taken to develop a basic package of essential reproductive and child health services that when implemented will reduce neonatal and maternal mortality in the participating districts.

Over the next three years, child health programs will be sustained and strengthened. Activities to combat endemic and emerging diseases will be lower-level intermediate results. MOHP support for the health policy program is expected to remain strong. A technical support mechanism is in place to assist the MOHP in building capacity for policy analysis and formulation. Cost recovery conversion will continue apace. In 1997, ten new hospitals will begin full CR conversion and MOHP decrees will be issued authorizing an additional 100 facilities to increase the number of beds operated on a fee-for-service basis. Ten additional hospitals are expected to begin full CR conversion in 1998 and another 25 in 1999. In 1997, the HIO management information system will be fully operational at the headquarters level and HIO branch offices and service delivery facilities 50% operational.

Gender information has been added to the tables. As expected, neonatal mortality is significantly higher for boys than for girls; however, post-neonatal and under-five mortality levels are higher for girls than for boys. Since mortality levels are generally higher for boys than girls even after early infancy, this pattern raises the possibility of gender-related differences in childrearing or child health care practices that place girls at higher risk of dying. The SO 5 Team will request secondary analysis of EDHS results looking for socio-economic and geographic factors that are associated with the higher risk for girl children. In addition, the neonatal practice studies that Mothercare is conducting will look at possible gender bias in newborn care. A review will be conducted on causes of death of young children to ascertain if there are gender-related patterns.

Result No. 5.1 under last year's framework, Increased Knowledge and Improved Health Behavior in Households, has been shifted from a double digit IR to a triple digit IR - 5.1.4 - under Improve Quality and Increase Utilization of Maternal, Perinatal and Child Health Services which was renumbered from 5.2 to 5.1. This shift recognizes that utilization and demand for quality health services are factors of how households behave.